MDR Tracking Number: M5-04-3921-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-15-04.

The IRO reviewed office visits, hot/cold pack therapy, electrical stimulation unattended, ultrasound, neuromuscular reeducation, massage, chiropractic manipulation and therapeutic activities rendered from 12-29-03 through 01-30-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-10-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

Review of the requestor's and respondent's documentation for CPT code **98940** dates of service 12-29-03 through 12-31-03 and 01-09-04 as well as CPT code **99211-25** date of service 01-09-04 revealed that neither party submitted copies of EOB's. The requestor submitted the reconsideration HCFA's, however no convincing evidence of carrier receipt of the reconsideration HCFA's was submitted per Rule 133.308(f)(2)(3). No reimbursement is recommended.

This Findings and Decision is hereby issued this 15th day of October 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202(b); plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 12-29-03 through 01-30-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 15th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 11, 2004

Re: IRO Case # M5-04-3921

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of

the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed in Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. TWCC work status reports
4. Request for travel reimbursement
5. D.C. treatment plan worksheet
6. D.C. SOAP notes
7. MRI left shoulder report 12/2/03
8. MRI cervical spine report 12/18/03
9. Report 1/24/04
10. prescription for medication
11. Reports 12/4/04, 6/10/04

History

The patient injured his neck and left shoulder in ___ when he pulled on a very heavy cable while working as a plumber. He sought chiropractic care. He has been treated with medication, physical therapy and chiropractic manipulation.

Requested Service(s)

Office visits, hot/cold pack, electrical stimulation unattended, ultrasound, neuromuscular reeducation, massage, chiropractic manipulation, therapeutic activities 12/29/03 – 1/30/04

Decision

I disagree with the carrier's decision to deny the requested services.

Rationale

The patient deserved an initial trial of conservative treatment. Treatment is considered reasonable and necessary with documentation showing resolution of symptoms and/or

improved function. The records in this case show continuing response to treatment, with

> improving subjective complaints and improved shoulder ROMs. On 2/11/04 it was reported that the patient's symptoms had resolved, except for some soreness in his upper back, and numbness in his index finger. His shoulder did not hurt, and there was no pain with lifting, pushing or pulling. The patient was able to return to work on light duty. Treatment was reasonable and necessary based on the documentation showing effectiveness of treatment and return to work.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.